West Virginia Public Employees Insurance Agency
Improve Your Score Premium Discount Program

CAUTION!

Using this form may result in additional costs to the policyholder including copayment, deductible and coinsurance! Free screenings are available through Pathways to Wellness and participating LabCorp sites. Go to www.peiapathways.com for details.

Worksite ID: 00109555

Mail to:
beBetter Health, Inc.
Attn: Rob Tuell
109 Capitol Street
Renaissance Tower, First Floor
Charleston, WV 25301
Fax Number - 1-866-900-4833

Instructions for Patient (PPB Insured)

1. Please complete the information below.
2. Submit sheet to Provider for completion
3. Fax **and** then mail the completed form to beBetter Health

Last Name: _____ First Name: _____ Home County: _____

Mailing Address _____ City _____ State _____ Zip _____

Work Phone (____) _____-_____ Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Date of Birth _____ /_____ /_____ Age _____ Gender M ☐ F ☐ Email Address _____

10 Digit Member ID# : 7700 __ __ __ __ __ __ *(located on insurance card)*

Last 4 digits of Primary Insured's SSN: _____

Last 4 digits of Family Insured's SSN: _____

Preferred Provider Benefit (PPB) members are encouraged to participate in the new Improve Your Score Premium Discount Program. As a health service provider, please complete this information below and return it to the patient (PEIA PPB primary insured member).

Instructions for Primary Care Provider (MD, DO or NP)

1. Please indicate the results for the following measurements/tests.
2. Complete the contact information, including signature and date
3. Return completed form to patient (PPB Primary Insured).

Waist Circumference: _____ inches Blood Pressure: _____/_____

Total Cholesterol: _____ Glucose: _____

Provider Contact Information

Name of Provider: _____ Name of Facility: _____

Facility Address: _____ Phone Number: _____

Medical Certification

I, _____, certify that the Patient indicated above has received the measurements/results indicated on this form.

_____ _____

(Signature of Provider or Representative of Services/Facility) ***(Date of Service)***

Please **fax** to **1-866-900-4833** Attn: IYS Program **AND mail** to beBetter Health.